TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

November 17, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3321–NC
P.O. Box 8016
Baltimore, MD, 21244–8016

Dear Sirs:

On behalf of the Texas Medical Association and our 48,000 physician members in the state of Texas, we thank you for the opportunity to comment on the "Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models" published in the *Federal Register* on Thursday, October 1, 2015. We are also grateful for the extended comment deadline, allowing us time to prepare a more thoughtful response.

We are very concerned that many of the compliance, documentation, and reporting requirements that will be implemented in the future Medicare system are wasteful, costly, and do little or nothing to improve care quality or increase efficiency. The requirements and incentives may even have the counterproductive effect of reducing access to good ambulatory care for some or all Medicare beneficiaries. If the goal is to reduce total medical cost, it is counterproductive to try to achieve that by increasing the total cost of medical practice. If the goal is better use of ambulatory care by patients, it is counterproductive to penalize the physicians who provide it. We urge CMS to use the following principles in developing implementation rules:

- Implementation must be administratively efficient, keeping new documentation and reporting requirements to an absolute minimum. When possible and relevant, documentation should be drawn from existing sources such as claims data or Medicare enrollment records.
- Physicians should be held accountable only for those aspects of cost and quality that they can reasonably influence or control.
- Physician choice of payment model should be preserved. No physician should be forced or coerced into accepting a payment model which is unacceptably risky for small practices, as small practices are likely to have a small and unrepresentative patient mix.
- All quality and meaningful use measures should be revised to exclude both:
    - The effects of patient care preferences or choices, and
    - Patient inability or unwillingness to adhere to medical orders or advice.
- All cost or utilization measures should be revised so that they do not cause adverse impact on physicians who treat patients from any socioeconomic, racial, or cultural group which may have diverse preferences for medical treatment.
- If cost or quality measures cannot be revised to remove socioeconomic effects, then risk adjustment methods for both cost and quality must include factors related to income, educational attainment, race and other cultural factors which affect patient choices and adherence to care recommendations.

- Meaningful use and clinical practice improvement requirements should only include activities that are proven to either:
    - Actually enhance care quality, or
    - Reduce cost with no adverse impact on quality or productivity.
- Meeting MIPS clinical practice improvement standards should not require any specific memberships or purchased products or services. New private programs to assist in compliance should be voluntary.
- All measures and compliance methods should be designed so that they do not penalize physicians who care for difficult-to-treat or non-compliant patients.
- Feedback reports should be timely, easy to access and to understand, and should include a process to request and implement revisions when data is incorrect.

Additionally, we endorse the specific recommendations and answers included in the AMA MIPS workgroup talking points which are appended below.

Sincerely,

A. Tomas Garcia, MD
President

ATG:mjd

APPENDED comments from joint workgroup:

CMS MACRA / MIPS / APM Request for Information
MIPS Workgroup Joint Talking Points
November 10, 2015

A. THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

1. MIPS EP Identifier and Exclusions

- The Centers for Medicare & Medicaid Services (CMS) needs to perform an internal environmental scan to determine the implications with creating a separate identifier and/or combining existing identifiers, i.e., the tax identification number (TIN) and National Provider Identifier (NPI). As CMS works through this, organized medicine is happy to set up focus groups with practice administrators to think through the administrative issues and implications that may arise with maintaining the TIN/NPI identifier combination.
- CMS should establish a simple and flexible process for identifying MIPS eligible professionals (EPs). The best approach is maintaining identification by each EP's TIN/ NPI combination that is in place for the current physician quality programs.
- Requiring all EPs to register with CMS to create a new, distinct MIPS identifier would create a potentially insurmountable administrative burden for both EPs and for the agency. We are concerned with the ability of CMS' existing infrastructure to handle the creation of a new distinct MIPS identifier, especially ahead of the start of the MIPS reporting period and with enough lead time to allow ALL EPs to register. It is also not clear that CMS would be able to administer payments or penalties sufficiently through a new identifier separate from a TIN, and whether it would require an addition to the 1500 claims form.
- By not moving forward with a distinct identifier, CMS will not have to worry about "poor-performing" EPs deliberately switching their distinct identifier.
- It may be appropriate to create a new MIPS identifier for virtual groups because they will consist of separate practices with separate NPIs, TINs, and likely separate ownership structures. Virtual groups will have to work out a coordinated structure in order to comply with the program, so creating a distinct identifier could be part of the natural progression of entering into such an arrangement.
- If a TIN registers as a group, during the registration process the group can self-designate how they will use individual NPIs to differentiate the various EP specialties and/or departments and their desired way to participate/report. CMS should be aware that there may be other circumstances that may need to be addressed as the policy moves forward.
- CMS must consider an individual EP's freedom to designate (or not participate) under the group's MIPS election. For many EPs, there are more relevant reporting options than the larger group's election. For instance, many large groups participate under the Group Practice Reporting Option (GPRO) web-interface, but a specialist may want to participate and report through a QCDR that is much more relevant to their patient population and site-of-service.

2. Virtual Groups

- There should be maximum flexibility for physicians, small practices, and other EPs to form virtual groups.
- There should be no initial, annual, or other limits placed on the maximum number of virtual groups that could be approved each year. Setting limits on the establishment of virtual groups, including the maximum number of groups, minimum or maximum size, geographic proximity, or particular specialty, would have a chilling effect

and discourage the EPs from pursuing this option. Such limitations could particularly harm the practices with limited resources and administrative support, which would most benefit from being in a virtual group.

- There is unlikely to be a flood of virtual groups signing up in the beginning, as smaller practices will likely take some time to learn about this option and take the actions necessary to form a virtual group. So this should not cause an undue administrative burden for CMS.
- It would not be appropriate to set arbitrary geographic limitations, including a 50-mile radius. This is unnecessary in a world where telemedicine and electronic communications are widely available. It also could hinder small groups of physician sub-specialties from joining together in a virtual group.
- EPs or small practices that practice in a certain specialty or sub-specialty may want to create a virtual group and report on the same quality measures and Clinical Practice Improvement activities. However, there should be no requirement that all EPs within a virtual group are within the same specialty.
- CMS may want to consider developing a separate identifier for each virtual group (especially virtual groups that do not already operate under a single TIN). This could be an "internal" identifier, solely for use by CMS, or an "external" identifier that the virtual group would also be required to use.
- EPs and small practices should be allowed to break away from larger TINs to form virtual groups. The remaining EPs within the TIN should be allowed to elect how they participate in MIPS or in APMs.

3. Quality Performance Category

a. Reporting Mechanisms Available for Quality Performance Category

Current PQRS Reporting Mechanisms and Criteria

- CMS needs to take advantage of this opportunity to fix things that are not working in the current quality reporting programs. At the same time, the initial transition to this new system needs to be as seamless and as non-disruptive to clinical practice as possible.
- At a minimum, CMS should maintain all of the current PQRS reporting mechanisms to ensure flexibility for physicians with different needs.
- We urge CMS to reconsider the current PQRS requirement of 9 measures across 3 domains, which is an arbitrarily high standard that often results in reporting for the sake of reporting and subsequent data that is of little value.
- Maintaining the 9 measure reporting requirement would also fail to recognize that the MIPS increases the total reporting burden of physicians with the addition of the new category of Clinical Practice Improvement (CPI) activities. CMS should keep in mind that for some physicians and specialties, some or all of the activities captured though this category may be more meaningful and accurate representations of quality than the current set of PQRS quality metrics. While organized medicine supports the goal of identifying national strategy domains, including the need to ensure a balanced national scorecard for quality, it is sometimes challenging to fit measures into these discrete boxes and ensure physicians within each specialty have an adequate suite of measures to meaningfully participate and comply with the program.
- The current domain assignment is very arbitrary and measures are moved from one domain to another from year to year. CMS needs to provide flexibility for a measure to satisfy multiple domains.
- We also believe that by adding the new category of Clinical Practice Improvement, CMS will inherently target a wider array of quality interventions that satisfy the goals of multiple domains.
- Consequently, **we recommend that CMS consider doing away with the domain requirement and instead use domains to simply guide measuring national quality goals.**
- Alternatively, if this is not possible, CMS should, at the very least, allow measures to be assigned and counted towards meeting multiple domains.
- We also would like to highlight that CMS' process of assigning domains and determining Measure Applicability Validation (MAV) clusters has historically occurred within a "black box." We urge CMS to give relevant stakeholders an opportunity to provide input into these determinations before domains and clusters are presented in proposed rules.

Quality Data Reported via Multiple Mechanisms

- A physician should not be allowed to report the same measure for the same patient across multiple mechanisms and have it count towards their score.
- However, there may be a need for a physician to report independent measures through multiple mechanisms and for those measures, in total, to count toward satisfying the quality measure reporting requirement. For example, an EP might identify a handful of clinically relevant electronically specified (e-specified) measures that can be reported through an electronic health record (EHR), but also might identify a few other relevant measures that are not yet e-specified and can only be reported through a registry. CMS should recognize the reporting of measures across multiple reporting mechanisms in order to promote meaningful engagement and to encourage EPs to experiment with different options.
- Combining methods would also enable multi-specialty groups to use multiple registries to satisfy reporting.

Quality Measure Types and Weighting

- Moving to more "high value" measures or "measures that matter" are important goals of the house of medicine. However, there is not uniform agreement on which measures have the greatest (or incrementally more) value in driving results. Measures considered "high value" may differ by specialty or patient, as well as varying depending upon the intended purpose.
- Valid and reliable outcome measures could potentially lead to more direct measures of quality and their development by medical specialties should be encouraged and funded. However, we also recognize that certain types of measures might be more appropriate for certain specialties and practice settings than for others. Furthermore, process measures that are evidence-based can be integral to improved outcomes and in some specialties, this foundational step must first be addressed before moving on to outcome measures.
- There are a number of methodological issues that must be addressed by CMS before moving to assigning more weight to outcome measures, including risk adjustment and attribution.
- Outcome measures at the physician level can also be particularly challenging to construct for two primary reasons—small sample sizes and the difficulty of identifying outcomes for which the physician can and should be held accountable (i.e., outcomes that are largely dependent on the quality of care received, not other factors).
- Infrastructure challenges may also prevent measure developers from developing outcome measures. These can involve problems with capturing patient reported or experience of care measures in the EHR as well as interoperability issues that interfere with the exchange of needed information, and the inability to do longitudinal tracking due to the lack of uniform patient identifiers.
- Therefore, CMS should maintain flexibility by not requiring the use of any specific type of measure in the initial years of the program. A flexible approach is critical to ensuring that relevant measures are available to as many physicians as possible.
- We are opposed to requiring that a minimum number of measures be outcomes-based and/or weighing outcome measures more heavily. CMS is assuming that individual physicians can wield sufficient influence on which measures are developed and available to meet the needs of their patient population. Holding physicians accountable for something that is not necessarily within their direct control would be imprudent. It also ignores infrastructure issues that may prevent the development or incorporation of appropriate outcome measures into CMS programs.
- In view of this challenge, we strongly advise CMS not to push forward with the development and maintenance of administrative claims based outcome measures, which are typically poorly designed, under- or over-capture clinical information, and often have attribution issues.
- Instead, CMS should encourage physicians to report on clinician-led and evidence-based outcome measures by recognizing and compensating for the increased effort required to report on patient outcomes. For example, if a physician reports on an outcome measure, CMS could consider eliminating or reducing other requirements such as reporting on 9 measures.

Data Stratification

- Stratifying data by demographic factors such as race, ethnicity, and gender is important to ensure equivalent quality and access to care among diverse patient populations. Documentation of these factors will result in more accurate measurements and more precise accounting for risk and other factors that can influence performance. At the same time, CMS must recognize the additional burden this could pose to the reporting physician and to the entities collecting this data, e.g., qualified clinical data registries (QCDRs).

- CMS should consider *directly* providing QCDR entities with more open access to CMS claims and EHR data so they can easily gather this information. As it is, many EPs and health entities are hesitant to participate in clinical data registries, even for quality improvement, due to fears of breaching the security or privacy of protected patient health data.
- Stratifying the data will also reduce sample sizes, creating further issues of validity and statistical significance.

The CAHPS Survey

- We support making the use of patient satisfaction surveys one way of satisfying the CPI category. However, CMS should also allow for other types of CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys, not just the CG-CAHPS (Clinician and Group CAHPS) and non-CAHPS "experience of care" measures and surveys, to count under the CPI category. We do not believe that patient experience and patient satisfaction should be categorized as a Quality metric since these measures and surveys include factors outside the control of the physician (e.g., physician wait times in a hospital setting).
- Patient satisfaction, while important, does not always correlate with better clinical outcomes and may even conflict with clinically indicated treatments. For example, a physician who recommends that a patient lose weight or stop smoking, or limits pain medications, is likely to receive a low "performance" score even when these are clinically indicated.

EPs in Specialties with Few Quality Measures

- For specialties that may not have enough measures, CMS should use its authority to re-adjust the weights of the other MIPS categories.
- Due to serious flaws in the current Meaningful Use (MU) and Value Modifier programs, we caution against automatically adding weight to the MU or Resource Use categories.
- The CPI category may provide the most flexibility for many physicians to receive recognition for the quality improvement activities that are most relevant to their practice. This category was also given the least amount of weight under MACRA. Therefore, we believe that when a specialty does not have enough measures, CMS should give more weight to a properly constructed CPI category, developed in cooperation with the affected specialties and sub-specialties.
- Alternatively, CMS could allow specialties to select which other category(ies) they would like to count more. We recommend that CMS customize the performance requirements for those EPs and work with the affected specialty and the related specialty society(ies) to set requirements that are appropriate for the unique nature of that particular specialty.
- Rather than taking a one-size-fits-all approach as it has with the current MU program, CMS must consider the varying practice patterns of specialties and sub-specialties, as well as the site-of-service in which a physician practices. This is particularly important for radiologists, anesthesiologists, and pathologists—as well as facility-based specialties such as physicians who practice largely in the hospital or in long-term care facilities and nursing homes.

Barriers to Successful Quality Performance

- The greatest barriers to success for many physicians are not having a sufficient set of relevant measures to choose from, or having too few patients to meet minimum standards for a statistically significant sample. And while QCDRs have allowed for the development of more diverse measures, this reporting mechanism is not yet accessible to everyone.
- CMS must continue to address measurement gaps and to improve the existing set of measures. We reiterate our concern that CMS has not yet allocated MACRA-authorized funding toward this effort, and we urge the agency to do so as expeditiously as possible. **We also remind CMS of the importance of ensuring that measure development is evidence-based and clinician-led.**
- Furthermore, we reiterate our concern about arbitrarily high reporting thresholds (e.g., 9 measures across 3 NQS domains) that force physicians to report on measures that are marginally relevant to their practice, simply for the sake of reporting.

b. Data Accuracy

Testing

- To enhance data integrity, CMS should provide validation on calculated reporting and performance rates as data is submitted by EHRs and QCDRS to CMS, including CMS flagging any errors on both format and values as data is submitted. Ongoing validation and auditing are also needed.
- To avoid data integrity problems such as those CMS encountered with 2014 data collected via QCDRs and EHRs, CMS should require these entities to complete preliminary CMS-sponsored submission testing. Currently this is highly encouraged, but not required.
- CMS and its contractors should work with QCDR and EHR vendors in their early stages in order to integrate processes for ongoing data testing. For instance, discussions on processes for system testing should occur once a QCDR self-nominates and submits its data validation plan.

Standards

- QCDR XML (Extensible Markup Language) and QRDA (Quality Reporting Data Architecture) are formats currently allowed by CMS for PQRS reporting. CMS should initially consider that using any method of electronic capture and transmission of quality data meets the intent of interoperability. It should not be required that certified EHR technology (CEHRT) uses only QRDA for capturing and transmitting data. Requiring CEHRT or QCDRs to only use QRDA will require time and resources to put this in place.
- That said, the 2015 Edition Certification requires that all health information technology (IT) modules used for the submission of clinical quality measure (CQM) data must at least be certified to the QRDA standard. While there are still concerns with the QRDA format—including EHR vendor compliance and testing—issues do arise when health IT products attempt to accommodate multiple standards.
- Transitioning to QRDA could help reduce vendor interface costs for physicians who are already using CEHRT and desire to participate in registry reporting. As a starting point, CMS should provide ample notification, testing periods, and conversion guidelines to allow for previous users (whether QCDRs or others) who report data in the XML format to transition towards QRDA I or III formats in order to remain in programmatic compliance.
- We also believe that CMS should work with registries and other stakeholders to identify emerging standards that support a more scalable and flexible data reporting format.

Review and Qualification

- It will require substantial effort by each QCDR to ensure its file transmissions meet the form and manner of CMS specifications. However, it would be beneficial for a QCDR to know at the start that its file format is accurate. To accomplish this, CMS should provide specifications and access to the testing portal to QCDRs for testing within a reasonable time period and prior to the CMS approval date (currently May). During that time, QCDRs should be able to test data for validity, as well as for data format.
- One problem with the current file format is that the standardized, one-form-fits-all does not always translate seamlessly for each QCDR. When developing formats for data submission, it is critical that CMS work with registries to ensure that CMS can accept formats which allow each registry to demonstrate the unique features of its data, such as embedded risk adjustment.
- We are also aware that testing tools used for "form and manner" compliance have in the past been delayed, error-prone, or had multiple versions for use in testing vendor products. Health IT systems rely on these tools to validate their quality reporting system and any issues with these tools can promulgate errors down the development time-line or into the production environment.

Feedback During Testing

- It would be helpful for CMS to inform stakeholders of calculation errors and anything that does not comply with specifications, such as zero rates.
- If testing requires any type of practice audit or request for information from practices for data validation purposes, CMS should inform vendors of any communication to practices so that vendors can work with CMS to ensure that practices understand the purpose of the validation request.
- In advance of, or concurrent with, updates to quality measures, CMS should clearly identify a timeline when testing tools will be available and at what point the version will be "static." Suggested milestones should be made available so that health IT vendors can incorporate measure testing into their product's timeline.

Thresholds for Data Integrity

- The overall goal of CMS should be to collect as accurate data as possible and not be punitive to the EPs for inadequacies of the QCDR and EHR and/or CMS' process. Therefore, we recommend that these types of issues around accuracy, completeness, and reliability should be validated during testing. However, it may not always be possible to validate a calculation rate for things such as continuous variables. Asking for calculated rate and elements provides a second order check, so it is important to have both.
- If a QCDR or EHR vender is alerted to errors and does not make corrections in a reasonable period of time, it would be appropriate for CMS to discard the records where validation is not feasible or results in inconsistencies.
- In an attempt to reduce the design burden around measure calculation and to help normalize reporting variations between health IT products, CMS should work with developers to establish a "black box" calculation system. This software module would be agnostic to vendors' products and could be hosted outside the health IT product or available as a plug-in through an application programing interface (API). It could be used (not required by CMS) as an alternative calculation application to help standardize reporting, reduce inconsistences that originate due to product design, or help better align with data integrity standards.

Non-Compliant Data Reporting Mechanisms

- If adequate opportunities for initial testing, validation, and data correction are available and a QCDR, qualified registry, or EHR vendor is still not adequately submitting correct and valid data, then the vendor should be placed on a corrective action plan. If after the probationary period the vendor is still not adequately submitting data, the vendor should be excluded from future performance periods until it shows through testing that it is able to submit valid data.
- To help resolve potential and ongoing issues, CMS should develop a root cause analysis toolkit that vendors could use to help self-identify issues. This analysis should be conducted before corrective actions are initiated. This would help inform CMS and other vendors about new issues or ones that may become systemic.
- If a vendor is found incapable of submitting accurate data, then EPs who used that vendor should be held harmless from any penalties. CMS must also recognize that there may be instances where the problem may reside with CMS and not just the vendor, such as a vendor not submitting complete information because CMS failed to provide necessary and/or timely information. In these instances, CMS should also hold physicians harmless from any penalties.

- We also urge CMS to consider developing a fair process or methodology to deal with future situations where the physician makes the good faith effort to comply, but the data is deemed invalid and unreliable. For example, why should physicians who received high performance scores in the past, be labelled as "average" just because a CMS error prevented them from having a valid report in the current year?
- We also strongly encourage CMS to notify through written mail any affected physicians and group practices when data is deemed invalid. The notification process to date has been essentially non-existent and grossly inadequate, which will become an even larger problem after MIPS takes effect and CMS quality programs are no longer just pay-for-reporting, but pay-for-performance.

c. Use of Certified EHR Technology (CEHRT) under the Quality Performance Category

- We support the current policy of allowing physicians to report quality measures through certified EHR systems to fulfill the clinical quality measure component of Meaningful Use. We also recommend that QCDR reporting count towards satisfying MU quality.
- CEHRT should only adhere to standards conformity and be tested for compliance. The use of CEHRT should not be proscribed beyond the constraints of the certification program of the Office of the National Coordinator for Health Information Technology (ONC), nor should it be limited to process objectives established by CMS. These requirements currently limit the utility of CEHRT by constraining the functionality of health IT to accommodate thresholds, measure calculation, and numerator/denominators.

Standards for Data Capture and Transmission

- QCDR XML and QRDA are formats currently allowed by CMS for PQRS reporting. CMS should initially consider that using any method of electronic capture and transmission of quality data meets the intent of interoperability. It should not be required that CEHRT use only QRDA for capturing and transmitting data. Requiring CEHRT or QCDRs to only use QRDA will require time and resources to put in place.
- That said, the 2015 Edition Certification requires that all health IT modules used for the submission of CQM data must least be certified to the QRDA standard. While there are still concerns with the QRDA format—including EHR vendor compliance and testing—issues do arise when health IT products attempt to accommodate multiple standards.
- Transitioning to QRDA could help reduce vendor interface costs for physicians who are already using CEHRT and desire to participate in registry reporting. As a starting point, CMS should provide ample notification, testing periods, and conversion guidelines to allow for previous users (whether QCRDs or others) who report data in the XML format to transition towards QRDA I or III formats in order to remain in programmatic compliance.
- We also believe that CMS should work with registries and other stakeholders to identify emerging standards that support a more scalable and flexible data reporting format.

4. Resource Use Performance Category

Current Measures

- The RFI implies that CMS may keep all the current Value-based Modifier (VM) cost measures and then expand upon them. The current measures have no clinical relevance for many physicians. Some have no costs attributed to them. Others are tagged with costs for services they had no opportunity to control. As can be seen in CMS' QRURs (Quality and Resource Use Reports) and VM experience reports, the current cost and outcome measures also discriminate against physicians with high numbers of chronically ill and high risk patients.

- There are many reasons for this, including an inadequate risk adjuster and cost of care measures that punish physicians repeatedly for the same high cost patients with multiple chronic conditions. Many of the measures were developed for hospitals and are inappropriate for physician practices, which do not have Medicare patient populations that are large enough or heterogeneous enough to produce an accurate picture of their resource use.
- Congress understood that the VM methodology is seriously flawed. That is why this category is worth only 10 points initially. We agree with that decision. We also agree with the MACRA's authors that improving the current episode-based measures and attribution process are critical to a fair and successful MIPS program and look forward to offering additional input as CMS complies with this mandate. CMS needs to devote significant data analysis and resources to this effort in order to ***replace,*** not ***expand,*** the current VM cost measures.

Measures Based on Potential Harm and/or Overuse

- Medicine supports the use by physicians of evidence-based clinical decision support systems to help guide their choice of treatment for particular conditions or patients. A growing number of specialties have developed and continue to expand and refine clinical guidelines and appropriateness use criteria (AUC). Also, as directed by Congress, CMS is currently developing a program that would require consultation of such guidelines for advanced imaging services and potentially others as well.
- The "Choosing Wisely" campaign is a related but different activity which was intended to promote a dialogue between patients and providers around **potentially** unnecessary tests, treatments and procedures.
- Neither of these concepts should be considered absolute recommendations regarding the appropriateness of a given test, treatment or procedure. Presented with the general Choosing Wisely guidelines, a physician or patient may conclude that a particular recommendation is not appropriate in a given circumstance. Similarly, due to the nature of their practice, some physicians may conclude that particular recommendations do not apply to a subset of their patients.
- As a result, some legitimate variation in adherence to AUC and therefore average costs is to be expected. In addition, CMS' current attribution methods frequently hold the wrong physician accountable for the cost of a given service.
- Until such issues are resolved, it would be premature to judge physicians' resource use based on AUC or Choosing Wisely guidelines. Instead, physicians who use these should be given credit under the Clinical Practice Improvement category.
- However, individual specialties might decide to use AUC or "Choosing Wisely" guidelines in the creation of resource use measures applicable to their members. In these cases, CMS could then consider adoption of any that have a solid evidence base and were developed through a multi-specialty, clinician-led process. All specialties that provide the service in question would need to be consulted prior to adoption.
- Furthermore, we do not believe that measures based on Choosing Wisely recommendations should be calculated from administrative claims data. Administrative claims data typically under- or over-capture overuse.

Physicians/Practitioners without Applicable Measures

- CMS should consult with specialties without enough measures to cover all of their members, about how to redistribute points from this category. For example, how points should be redistributed will

likely depend on which, if any, other MIPS categories have measures or activities that are more applicable for physicians without applicable resource use measures.

Physicians/Practitioners without Enough Data

- A related question addressed in another section of the RFI involves the question of how to deal with physicians and practices that do not have large enough Medicare populations to compute reliable scores.
- Even with a low-bar minimum case threshold of 20 patients, more than 40 percent of groups with 25 or more practitioners did not have enough data to create scores for the 2012 QRURs. Under current VM policy, CMS simply declares that these practices have "average" costs. This protects the practice from cost-related VM penalties but it also precludes a practice from using a good score on the cost side to offset a bad score on the quality side.
- CMS should modify this policy to ensure that no practice is disadvantaged by the "small numbers" data issue. Alternatives are to call practices without enough data to calculate either a resource or quality score "average" on both categories or exempt them from mandatory tiering if that is retained in MIPS.

Episode-Based Cost Measures

- In addition to their other flaws, VM measures today are irrelevant for many physicians—either because no patients get attributed to them or because they had little to no opportunity to influence the costs that are attributed to them. Shortcomings in the attribution and risk adjustment methodology exacerbate the problem. If properly selected and designed, measures tied to episodes of care could increase the relevance, reliability, and applicability of resource use measures and make physician feedback reports more actionable. This would also offer an opportunity to adapt risk adjustment and attribution methodologies to the individual condition or service being measured.
- Transparency and physician involvement in the development of these measures and the accompanying methodological decisions are critical. We strongly believe that CMS should create a process that provides an opportunity for thorough input from practicing physicians throughout the process. Posting episodes developed by a contractor working with a handful of "experts" on a web site will not be sufficient. We appreciate the work that CMS has done in testing episode measures through the QRURs.

Aligning Measures

- The first order of business should be to ensure that measures used in individual MIPS categories are valid, reliable, relevant, and actionable.
- Episode measures potentially could include both costs and outcomes. This would require the identification of specific outcomes related to the condition or service being measured, rather than some general measure such as All Cause Readmissions.
- Alignment with measures in other parts of Medicare will need to be determined on a case-by-case basis with relevant specialties, taking into consideration their site of service. Wholesale incorporation of other providers' cost measures into MIPS should be approached with caution and only after testing and re-specification of the measure.

Peer Groups

- Due to the diversity of physician practices even within the same specialty, making accurate comparisons of their performance will require far more detailed delineation—of specialty, sub-specialty, area(s) of expertise and/or site(s) of practice—than is currently conducted by either Medicare or private payers. While we appreciate CMS' efforts to adjust for a physician's specialty in the VM program, more work is needed.
- A means of recognizing sub-specialization, either due to training, services provided, or site of service, will need to be developed and implemented.
- Site of service should also be used to make adjustments for physicians whose practices focus on hospital or nursing home patients, whose care is typically more complex and more costly than patients outside a facility.

5. Clinical Practice Improvement (CPI) Activities Performance Category

Types of Qualifying Activities

- CMS should allow for the broadest interpretation of CPI activities possible. The selection of activities should be optional. No category should be mandatory.
- Physicians and other eligible professionals should be given credit for CPI activities in which they are currently engaged, including those that are mandated or encouraged by Medicare and other government programs. This would include a long list of activities such as:
    - Participation in a Qualified Clinical Data Registry and in registries run by other government agencies such as FDA or private entities such as a hospital, or medical specialty.
    - Certain quality measures from other provider types such as the safe surgery checklist and flu vaccination measures for the Ambulatory Surgery Center Quality Reporting Program.
    - Compliance with a coming requirement for consulting Appropriate Use Criteria for advanced imaging services.
    - Participation in CMS' Million Hearts Campaign, Cardiovascular Disease Risk Reduction Model, Oncology Care Model, and/or Transforming Clinical Practice Initiative,
    - Participation in relevant practice improvement activities facilitated by each state's Quality Improvement Organization.
- Other activities associated with the six CPI categories Congress specifically called for in the MACRA include the following types of activities:
    - Expanded practice access: Same day appointments for urgent needs; after-hours clinician advice – using secured messaging, patients can ask questions of their provider that is well documented in the patient record; remote monitoring of chronic conditions; establishing policy allowing patients with emergencies to walk-in during certain established hours; Saturday and expanded hours for clinics to increase access; use of satellite offices to bring services to patients; and serving on call in an emergency department.
    - Care coordination: Timely communication of test results; ability of a practice to receive and act upon fax or email from a referring doctor; ability to provide patients with printed copies of test results; and billing chronic care management or transitional care management codes.
    - Beneficiary engagement: Practices providing patients with the option to download or have mailed medical history forms to fill out prior to a first appointment; training of patients in appropriate administration of medications and proper use and maintenance of durable

medical equipment and various remote monitoring devices and home testing products; use of decision trees and questionnaires to engage patients in shared decision making on their medical care; patient flyers for specific conditions; and nutritional counseling.

- Various activities of organizations representing physicians and medical groups should also be recognized as practice improvement. This would include accredited continuing medical education, board-certification-related activities, and other initiatives aimed at improving clinical practice, such as opioid prescriber training and the provision of medication-assisted treatment of opioid use disorders.
- Administration of CAHPS or other patient experience and satisfaction surveys should be considered as a CPI activity rather than a quality measure.
- Participation in designated private payer CPI activities.
- Physicians and other EPs should have the freedom to choose the CPI activities that are most beneficial and appropriate for their type of practice and patient population, regardless of subcategory domain. Subcategories should only serve as a guide for defining CPI activities.
- Activities aimed at reducing disparities in care or furthering other socially desirable goals should be completely voluntary and equally weighted with other activities.
- We would strongly oppose any efforts to use the CPI portion of MIPS as a backdoor way of forcing physicians to participate in various federal health programs such as Medicaid or the federal exchanges.

Attestation and Reporting of CPI Activities

- Physicians should be able to demonstrate their performance of CPI activities through a simple attestation process. Attestation should occur annually.
- The attestation process would be best facilitated through a web portal that is simple to access and use.
- Transmission of CPI activity results also should be permitted but not required through EHRs and QCDRs, when and where the capabilities exist.
- The physician or other EP should generally be responsible for documenting CPI activities. Participation in some activities could be reported on and/or collected from claims.
- Organizations and other entities that sponsor CPI activities should be required to maintain records for up to a certain period of time that can be used to verify physician or other eligible professional participation in a CPI activity.
- Some CPI activities (e.g., a certification) may be granted by the certifying organization for more than a one-year period. In such cases, physicians and other EPs should be allowed to attest to that activity for each of the years until the certification expires. After the initial year, the physician or other EP should not have to demonstrate anything additional in subsequent attestations until the certification expires, unless additional actions are required by the certifying organization.
- Where applicable, there should be an option of having participation in a CPI activity reported by the certifying agency rather than individual physicians. An APM Entity should be allowed to provide participation rates for physicians in the APM.

Thresholds and Quantifying Activities

- CPI activity performance should be based on completion *or ongoing participation* in a specified number of clinical improvement activities, rather than hours.

- CPI activities should include those in which an individual physician or other EP can participate or complete, *or* activities in which participation or completion occurs at the group practice level.
- Initially, the number of required CPI activities should be based on practice size.

Weighting of Various Activities

- At least initially, all CPI activities should be weighted equally.
- All CPI activities, regardless of subcategories, should be weighted equally while experience with the program is gained.
- Physicians should not be required to attest to a CPI activity in every subcategory or any specific subcategory or activity. They should be able to pick and choose, so these would have to be weighted equally.

APM Participation

- The subcategory of participation in an APM should not be limited to qualified APMs. The definition of the APM subcategory under MIPS should include physician or other EP's participation in an APM "sponsored" by a commercial payer or Medicaid.

Small and Rural Practices

- Allowing for the broadest definition of CPI activities and least burdensome requirements will be needed to ensure that physicians and other EPs in small or rural practices are able to participate.
- Ensuring that there are options which are free or low cost will also be crucial. For example, many physicians issue disease and population-specific notifications and perform other activities without the use of a certified electronic medical record, and this should be counted as CPI.

Best Practices

- Initially, CMS should allow for the broadest definition of CPI activities and, simultaneously, work with stakeholders to identify best practices based upon community and population needs.

6. Meaningful Use of Certified EHR Technology Performance Category

Overview

- Since Meaningful Use (MU) is one component of the MIPS program, it is extremely important that, prior to its implementation, CMS make changes to the program that will ensure that MU is achievable and meaningful for all physicians, including specialists.
- CMS should reopen Stage 3 Meaningful Use to realign the program and take time to evaluate whether providers are successful under the Stage 2 Modifications rule.
- Incorporating Stage 3 – as finalized by CMS into the MIPS program– will prohibit physicians from being successful, and therefore, jeopardize their ultimate MIPS composite score.

Stage 3 objectives should score in an accumulative fashion toward the 25 percent of the MU category. In other words, if an EP fails to satisfy an individual measure, and does not meet the prerequisites of any available exclusion(s) from the failed measure, that EP should only lose a smaller, proportional percentage—not the full 2 percent.

Redesigning Stage 3

- CMS should return to the statutory intent and focus Stage 3 on the three categories outlined in the law: 1) electronic prescribing; 2) information exchange; and 3) quality reporting. MU measures should be redesigned to focus on outcomes and use cases rather than processes and data entry. Rather than emphasizing counting and thresholds, measures should focus on whether data is accessible and usable.
- CMS should collaborate with national specialty societies to develop health IT-enabled alternatives or pilots that could be optionally used to satisfy the MU component of the composite score. Radiologists, for example, should be given the option to participate in MU Stage 3 or satisfy an alternative pathway that could be comprised of elements of MU, such as clinical data registry participation, data security/HIPAA checks and updates, and implementing clinical decision support functionality. In addition, those looking to move to alternative payment models could pilot alternatives to the MU program that assist in moving to new payment and delivery models.
- CMS could also implement additional health IT-enabled activities outside the scope of the current MU requirements such as imaging data-sharing, structured reporting, enabling electronic orders, etc. The ONC could readily establish health IT certification criteria for other IT functionality that supports these alternative actions. However, CMS and ONC would need to work closely with the national specialty societies to appropriately plan and implement these alternative pathways.

Partial Credit for Meaningful Use Attestation

- If providers are attesting for MU and meet a certain percentage of the measures, there should be an option for them to get credit for the percentage they were able to complete.
- It should not be an all or nothing system.
- CMS needs to eliminate the pass/fail approach.

We strongly disagree with the tiered approach. Using a performance-based/tiered methodology for the MU component of the composite score would unfairly penalize certain participants based on circumstances largely outside their control—such as subspecialty/scope of practice, location/setting, health information exchange (HIE) network availability, business environment/competition, and patient population, among others.

Moreover, many MU participants satisfy the requirements of the program, in part, through meeting the prerequisites of available exclusions from certain measures rather than satisfying the measures themselves. The exclusions exist to allow MU's single list of participation requirements to account for scope of practice differences and other variations. Exclusions should qualify as fully meeting the measure and not result in a lower score for the MU component.

Interoperability

- Given that there are significant interoperability issues in the current MU program, CMS must ensure that EHR systems address these challenges and resolve basic cornerstones necessary for data exchange, such as patient matching, provider directories, standards, and privacy and security.
- Well-documented issues with certain measures, such as sharing summaries of care, must be resolved before physicians are held accountable for these actions.
- CMS should focus on increasing the functional interoperability between vendors and among vendors and registries to ensure MU is a program that improves healthcare, and not another unnecessary regulatory burden on providers.
- Interoperability should not be measured by how much data is exchanged but instead should reflect a business case. For example, interoperability could be tied to improving transparency, ensuring that physicians have relevant clinical information, patients have relevant cost information, etc.
- Meaningful Use should reduce data blocking to ensure that EHR vendors are sharing data with each other and are also sharing it with the registries.

Hardship Exceptions

- There should be significant flexibility in the type of hardship exceptions that are offered for Meaningful Use.
- Many physicians face unique situations that may not fall into an established hardship exception category, but cause the provider to be unable to meet Meaningful Use.
- Providers should not be punished or penalized for taking a hardship exception. If a provider chooses to file a hardship exception, they should not be penalized in the MU performance category and should have options on how to reweight the other MIPS categories.
- Many physicians are forced to take a hardship exemption through no fault of their own, e.g., their EHR vendor had delayed updates, inaccurate information, faulty software, etc.
- These providers should not be penalized for the inability of their EHR software to complete Meaningful Use, and therefore, this should not affect their MIPS composite score.
- Hardship exceptions should not be capped at five years, since many practices simply cannot participate due to their specialty or patient population.

Measure Concerns

- CMS should work with specialty societies and other stakeholders to reduce the required thresholds to more reasonable levels and develop measures that are appropriate and meaningful.
- All measures should be assessed to determine:
    - The relevance to all specialties and the conditions they treat;
    - The cost-benefit analysis, including the cost of lost productivity; and
    - Whether actions are controlled by the physician and not by patients, technology, or other factors over which providers have little influence.
- Measure example: That 10 percent of all patients view, download, or transmit their health information or access their information through an API, or a combination of the two. CMS addressed this in the MU Modifications rule – and lowered the initial 5 percent requirement – but now has increased it, making it even more difficult to meet. It is counterintuitive for CMS to revert back to an increased threshold for this measure.
- Another measure example: That in more than 50 percent of transitions of care and referrals, the EP creates a summary of care and electronically exchanges the summary of care record. Many EPs are located in areas where the doctors they refer patients to and receive patients from do not have EHRs. Therefore, it is impossible for EPs in these areas to meet this measure, and they should not be penalized for the inaction of others in their area to adopt EHRs.
- Furthermore, any objective new to MU (not currently in MU Modifications) should, at least for the initial reporting period, not be tied to any thresholds. The objective should only be enabled and provide time for both physicians and patients to maximize the measure's utility without being burdened by measurement.
- CMS should allow physicians to select a six-month minimum reporting period at least during early years/transition.
- **Overall, providers who are attempting to attest to Meaningful Use should not be penalized for actions they cannot control. CMS should ensure that each measure required for Meaningful Use is one that providers are able to attest to without relying on the actions of other individuals (patients, technology, or other providers).**

7. Other Measures

- Based upon experience with the incorporation of hospital measures into existing physician incentive programs, we have serious reservations about a widespread application of other provider groups' measures to the MIPS. In some circumstances, the use of another provider's measures, once they have been re-specified, tested, and validated for use by physicians, could potentially be an appropriate option for certain specialties, particularly those that practice largely within a facility. However, the use of other system measures should not be mandatory.
- CMS should also allow for the optional attribution of the facility-based score to EPs who practice in or are employed by that facility, and compare it to the national average for similar facilities as the benchmark.
- The MACRA includes language about the specialties that can potentially have facility/hospital-based measures attributed to them. However, we do not believe the law precludes CMS from considering specialties that practice in other sites of services, such as nursing homes, assisted living, or home health, and treating them in a different manner. Given the different patient populations these specialties treat, it is inappropriate to assume they can be compared to other internal medicine/family physicians that practice in the ambulatory setting. The costs and resources for

treating these patients are different and often higher. In addition, the quality measures are often inappropriate and do not match the patient population they serve.

- We acknowledge there must be a certain minimum percentage of services performed at the "facility," but there is not enough information in the RFI to provide a recommendation on an exact number. Therefore, CMS should perform some internal analytics to determine the typical practice patterns of facility-based specialties before proposing a recommended number, and then provide an opportunity for stakeholder comments. As part of the analytics, CMS should also consider situations where physicians practice in multiple facilities.
- We recommend that CMS allow non-patient facing EPs the option of completing the standard requirements of the MIPS performance categories or completing alternative pathways for any of the four categories that offer alternative measures. If CMS will not consider *optional* alternative pathways, we recommend that CMS weight the CPI category higher for non-patient facing and facility-based physicians, to allow for a broader scope of activities that realistically reflect their actual practice patterns and patient populations.

8. Development of Performance Standards

The comments that follow offer some brief and preliminary thoughts that our group plans to refine in the future.

General Thoughts

- The RFI appears to take for granted that CMS will continue to base payment adjustments upon a performance period that occurred two years earlier. This forces the agency to truncate development of policies and hinders timely modifications in the program. It also means that physicians have little or no idea of what Medicare is judging them on. We strongly urge CMS to make every effort to reduce the gap between the performance period and the payment year.
- Physicians and groups need to know who they are being compared to, what their thresholds are, and what precisely they are working toward. We urge CMS to prioritize outreach and education to empower providers and groups to operate with clarity in MIPS.
- Performance standards should not change periodically, as CMS suggests in the RFI. Rather, the standards for one performance year should remain the standards throughout the entire performance year.

Historical Performance Standards:

- Although the law requires CMS to "***consider***" historical performance standards, it stops short of requiring the agency to ***"use"*** historical standards. Given the imperfect and still changing nature of the current incentive programs, it is preferable to use some future year as the basis for determining historical performance.
- In the interim, CMS should consult with medical organizations to identify potential sources of data, including QCDRs, for historical performance standards.
- Since a very large percentage of physicians will have VM scores that are not based on actual data and many others will have scores that bear little relevance to their own performance, the VM would be an ill-conceived foundation of performance under MIPS.
- The development of standards that differ according to size and other practice features seems worthy of investigation and could be better evaluated through an analysis of QRUR and VM data.

- In addition, CMS should refine the VM specialty mix adjustments to ensure that performance comparisons are applied to groups of similar characteristics. These calculations should be very clear and highly transparent, so that physicians can understand them and be successful in MIPS.
- Based upon the legislative language describing the new CPI category, we do not believe that Congress intended for CMS to somehow measure whether or not a particular activity "improved" care. The logistics of measuring how many patients took advantage of after-hours care, e-mailed a doctor, or utilized other services visualized in the law, are mind-boggling.

Defining and Incorporating Improvement

- The MIPS is not designed to be a tournament-style program, as CMS is required to disclose what benchmarks are prior to the start of a performance period. As such, generous education and outreach must be used in concert with performance standards development so that groups and providers know exactly who their peers are and what their goals will be.
- Improvement should be defined as year over year improvement. However, CMS should not introduce methodologies that are untested, at least without significant outreach to and input from the medical community, to ensure physicians understand and trust what they are being scored on.
- In the Hospital Value-Based Purchasing program, participants can win points for improvement as compared to the baseline, and additional points for achievement as compared to performance from the prior year. We question how this could work in the physician world where thousands of group practices operate in a fluid environment of recruitment, acquisition, expansion, and reduction. If a particular group improves one year but the payment adjustment is applied two years later, the providers or groups responsible for positive results may no longer be part of the group and may never see any reward for their achievements. Conversely, those who achieved success somewhere else and then moved to a group with low performance two years earlier will be penalized instead of rewarded for their efforts.
- We caution CMS against using a composite measure of improvement. Success in one category does not mean success in another. Likewise, failure in one category does not indicate failure in another category.

9. Flexibility in Weighting Performance Categories

- There clearly are situations where certain EPs could not be assessed at all for purposes of a particular performance category. For example, if there are no measures specific to the conditions that a particular specialty treats and the type of care they provide, then physicians in this specialty would need flexibility regarding their quality component score. Quality activity needs to be meaningful and related to the actual services a physician personally delivers. General primary care measures should not be viewed as fulfilling the need for specialty-based measures.
- Also, hospital-based specialists, who weren't eligible for incentives related to the Meaningful Use of EHRs, should not be held accountable for that activity.
- To account for the percentage weight that would have been applicable to the quality where performance measures are lacking, CMS should work with affected medical societies to determine how the percentage weight should be re-distributed and whether CPI activities could have their weight increased to make up for the lack of quality measures.
- To identify the types of practitioners where insufficient measures justify flexibility in the weighting, CMS could establish a process for pre-review whereby each practitioner could submit the measures and activities they believe are available to them. CMS would then give them a "pre-determination" regarding whether these would be sufficient for the given years' MIPS index. In the event that CMS

found that the EP had not submitted all the existing activities available, CMS would provide them with a report as part of this pre-determination process.

- As part of this pre-determination process, CMS would use the difference between the percentage of activities available to a practitioner versus 100 percent, to re-weight the other categories.
- CMS should also set up an appeals and communication process with EPs after they receive their quarterly feedback forms to ensure their progress towards 100 percent.
- Reweighting determinations should be based on specialty or sub-specialty rather than applied at the measure or activity level. The ability to be successful should be determined based on the measures and activities that are available for each EP in that given specialty or sub-specialty.
- As has been demonstrated in the Value-based Modifier program, the appropriate threshold will vary depending on the measure involved. There is no single threshold that is applicable for all measures within a category. CMS should keep in mind that measures developed for hospitals often require the use of minimum thresholds that make them inappropriate for use with most physician practices.

10. MIPS Composite Performance Score and Performance Threshold

- Additional detail and analysis is needed in order to answer the questions in this section. We look forward to providing further input going forward.

11. Public Reporting

Minimum Threshold

- The MIPS is essentially an opportunity to press the reset button and to learn from mistakes made in the past, including rushed and sometimes imprudent implementation of certain policies. We would suggest that CMS first work on carefully designing the MIPS system; accrue a minimum foundation of data using the new system (e.g., at least 2 years of data); confidentially share that data with practicing physicians via clear, easy to understand feedback reports; and simultaneously conduct research into what information and reporting formats are most valuable to consumers and physicians. Only after this work is complete should CMS transition to the public reporting of physician performance data.
- Similar to current programs, such as the Physician Quality Reporting System (PQRS), the early years of the MIPS could include the public reporting of data which indicates whether an EP satisfied the reporting requirements for the multiple components of MIPS. But we believe that attempting to accurately calculate and showcase performance data for public consumption is an unrealistic goal for the initial years of this new program. There are currently too many unresolved problems related to risk adjustment, attribution, appropriate sample sizes, and even the ongoing lack of relevant measures for certain specialties. The public reporting of performance data, in many instances, would be premature.
- When making decisions about whether a measure is ready for public reporting, CMS should continue to adhere to its current policy of selecting only those measures which prove to be valid, reliable, and accurate upon analysis; are deemed statistically comparable; meet a minimum sample size of patients; are not first-year measures; and have proven, through concept testing, to be of value to consumers.
- With regard to appropriate minimum patient thresholds, CMS should keep in mind that these thresholds may vary across measures and even across specialties. It is perhaps better to focus on ensuring that a specific reliability score is obtained, such as 0.70, rather than focusing on minimum sample sizes.
- The number of patients or cases required will vary based upon the measure, the population included, and whether the measure is focused on an outcome or process. Because of the large number of medical specialties, patient populations, and mix of measures, selecting one minimum number of patients for everyone is not optimal. There is increased potential for CMS to incorrectly categorize and potentially penalize physician performance when the issue is due to a lack of reliability in the data, and not true variations in care.
- The process of determining whether measures are ready for public reporting should occur in as transparent of a manner as possible and should rely heavily on relevant clinical expert input. The current process is opaque as there is no opportunity to comment on the Physician Compare Technical Expert Panel recommendations.

- We also caution against using raw file downloadable databases to present data to the public that is not quite ready for posting on physician profile pages. We are concerned that such data could be misleading, misinterpreted, or misused by the public. We recommend that CMS first make the data available, confidentially, to professional societies for internal analysis. Professional societies have significant expertise in identifying shortcomings with measure calculations and data.

Stratification of Data

- All patients deserve equal access to high quality care, and stratifying data might help to identify and reduce disparities in care. Nevertheless, CMS first needs to address more foundational challenges related to public reporting (e.g., appropriate sample sizes, accurate attribution, and meaningful formats). Attempting to stratify data before these foundational issues are addressed would only further complicate the endeavor and produce potentially inaccurate, more confusing, and less actionable data for physicians and the public.
- Targeting health disparities at the individual physician level may not be practical due to small sample sizes and other methodological issues that might result in misleading and confusing information for the public. Targeting disparities is a larger system goal that might need to be addressed with systems-level measures, not measures that are reported at the level of the individual practitioner.

12. Feedback Reports

- CMS must provide ongoing, real-time feedback on performance and should consult stakeholder groups continuously to determine the best presentation and most meaningful format for sharing ongoing, actionable performance feedback information with physicians and practices.
- As technology is constantly changing, it will be critical for CMS to take an ongoing approach to improving the way performance information is disseminated to physicians and practices. Stakeholders must be included in this process so that feedback can be provided in a format that works best for physicians and is meaningful to their practice's ongoing improvement activities.
- CMS must be forthcoming in any feedback reports in regard to the methodologies used to comprise any benchmarks or attribute patients for a particular measure. This information must be clearly identified and easy to interpret.
- Current feedback reports lack key details to understanding the methodologies used to arrive at the benchmarks and other calculations made. This creates frustration and distrust, and must be avoided going forward. A successful payer-provider relationships stems from mutual trust and understanding between both parties involved.
- Where appropriate, CMS should aim to display feedback and performance measurement information in graphic form with additional details displayed elsewhere.
- Detailed information should be provided in feedback reports, including the ability to see high-level, overall performance information, as well as drill down tables with individual patient information. CMS must continually consult with stakeholders to ensure displayed data is relevant and meaningful, and understood by the intended audience.
- Web-based reports as well as dashboards and paper reports should be made available.
- Feedback reports should be accessible to physicians, practice administrators, and related officials. The log-in process for accessing reports must be simple and user-friendly. There have been ongoing problems with accessing reports due to the overly complicated log-in process and cumbersome password requirements which reset at very short intervals, complicating the log-in process and ultimately limiting access to these reports. CMS should make staff available to help physicians and administrators interpret the reports.
- CMS must provide a fair and transparent process for providers to appeal findings in feedback reports, and should lengthen the appeals process to at least 90 days.